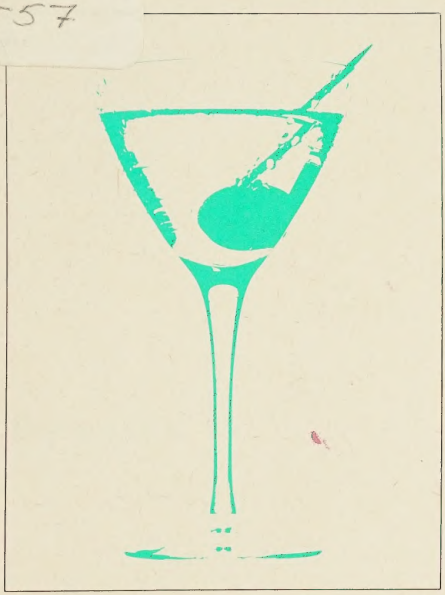

by H. David Archibald

TOWARD SATURATION - IN SEARCH OF CONTROL

Alcohol use in Ontario in the mid-70s

Mr. Archibald is executive director of the Addiction Research Foundation. This article originally appeared in *Addictions,* Fall '75 and was adapted from the keynote address to the 16th annual Institute on Addiction Studies held in August, 1975 at McMaster University, Hamilton, Ontario. The article, and the preceding notes on alcohol use in Canada are published to replace two existing A.R.F. publications, *Alcohol Use and Alcoholism* and *Changing Drinking Patterns in Ontario—Some Implications.* Tables reprinted with permission from *WHO Expert Committee on Drug Dependence,* World Health Organization, Geneva, 1974.

Foreword

Alcohol use in Canada continues to escalate.

In the fiscal year ending March 1974, Canadians spent $2.6 billion for over-the-counter purchases of liquor, beer, and wine. This sum does not include money spent in bars, taverns, and restaurants.

During the 1960s, average per capita use of alcoholic beverages in this country jumped by more than 22 percent so that by 1970 Canadian adult consumption, per capita, ranked 16th highest on a scale of 49 countries. This was considerably below France and Italy, but above the United States, the UK, Sweden, Japan, the USSR, and many others. (Schmidt, de Lint—control paper, Berkeley).

As for the people of Ontario, whose consumption is above the overall national norm, each adult in 1972 averaged 2.3 gallons of pure

alcohol—enough to make approximately 300 bottles of beer, six bottles of wine, and 12 bottles of liquor. (Interministerial driving redbook).

If this level of drinking denoted nothing more than a buoyant economy, then there would not be much cause for concern. But the fact is that this consumption has resulted in serious health and social welfare consequences—ones that are costly in terms of dollars as well as human suffering.

A study of adult drinking patterns in Ontario, prepared on 1969 data, showed that 10.7 percent of male and 2.7 percent of female drinkers consumed at least 9 ounces of liquor (or its beer or wine equivalents) each day. Consistent drinking in these amounts has been linked to elevated risk of liver disease, heart and circulatory problems, and many other forms of illness.

Moreover, at least 5 percent of male drinkers and 1.4 percent of female drinkers consumed at least 13 ounces of liquor or its equivalent daily—a level denoting alcoholism. That was 1969 data. Since that time consumption has risen even more.

Alcohol and Alcoholism

Estimating the numbers of alcoholics in a society that uses this drug so widely has become a highly-refined scientific process. The epidemiology of alcoholism is based on many different information sources including death statistics, arrest data, hospital admissions, beverage sale records, cirrhosis data, and specific research studies.

Through such information it has been possible to define a clear mathematical link between alcohol-related disease and prevalence of alcoholism. In effect, the more widely and consistently a society uses alcohol, the more alcoholism it experiences.

There are still many individuals and institutions promoting the contention that alcohol is not at fault in the cause of alcoholic diseases. They say the cause lies in the person of the alcoholic, that he is somehow unique, different in his physical or mental makeup. They contend that by virtue of this difference he is driven to use alcohol to excess.

They believe that the alcoholic is "destined" to be so, that his drinking

TABLE I. RELATIVE PRICE OF BEVERAGE ALCOHOL, CONSUMPTION (INCLUDING PERCENTAGE CONTRIBUTION OF DISTILLED SPIRITS), AND DEATHS FROM LIVER CIRRHOSIS IN VARIOUS COUNTRIES

Country	Alcohol consumption [a]	% contribution of distilled spirits to total alcohol consumption [b]	Relative price [c]	Death from cirrhosis of the liver [d]
France	24.66	13.5	0.016	51.7
Italy	18.00	12.6	0.027	30.5
Portugal	17.57	4.1	0.023	48.0
Austria	14.47	18.2	0.025	38.5
Federal Republic of Germany	13.63	21.2	0.026	29.0
Australia	10.71	[e]	0.029	7.8
Czechoslovakia	10.27	17.4	0.080	14.8
Canada	8.95	36.0	0.029	11.6
Belgium	8.42	15.0	0.022	14.2
United Kingdom	7.66	14.2	0.057	4.1
Ireland	7.64	34.4	0.092	5.0
Denmark	7.50	17.2	0.069	11.6
Netherlands	6.19	37.0	0.028	5.7
Finland	4.16	46.7	0.117	5.4

[a] Litres of absolute alcohol consumed *per capita* for persons aged 15 years and older in 1966 or 1967. Data collected by the Addicition Research Foundation, Toronto, Canada.

[b] de Lint, J. & Schmidt, W. (1971) The epidemiology of alcoholism. In: Israel, Y., ed., *Biological basis of alcoholism,* New York, John Wiley & Sons; Produktschap voor Gedistilleerde Dranken (1969) *Verslag over het jaar, 1968,* Schiedam.

[c] The cost of 10 litres of absolute alcohol as contained in the least expensive beverage available to the consumer, divided by personal disposable income. Data were obtained by the Addiction Research Foundation, Toronto, from the appropriate government departments in each country.

[d] Annual rate per 100,000 persons aged 20 years and older. Data taken from the *Demographic Yearbook 1966,* New York, Statistical Office of the United Nations, Department of Economic and Social Affairs, 1967.

[e] Data not available.

style develops independently of the actions of those around him, and that he would be an alcoholic regardless of the sanctions society placed on his favorite beverage.

The thrust of this argument is that society ought to concentrate preventive and control efforts on the "susceptible few" and not "interfere" with the drinking customs of the majority. Unfortunately, it's an argument that cannot be defended on the basis of scientific evidence.

In a culture where alcohol consumption is low, where it is frowned

upon and where its acceptance is restricted, there are few heavy users. In this setting, a person with latent tendencies towards heavy alcohol use is less likely to have his drinking reinforced.

Scientific studies show that nations that have high alcohol-consumption levels have the greatest prevalence of alcohol-related illness. The more people there are in any society who drink—even though most may drink moderately—the more alcoholics there will be, and the greater the incidence of alcohol-related health damage.

Both France and Italy, often cited as models of civilized drinking, in fact have very high rates of alcoholism, even though obvious drunkenness is comparatively rare. In France, more than 42 percent of total health expenditures are attributable to the treatment of alcohol-related illness. In Italy, where per capita consumption is second only to France, the liver cirrhosis death rate is six times higher than it is in Finland where alcohol is expensive and much less accessible.

A survey of 14 nations, reported by the World Health Organization in 1974 (Table I) showed positive correlations between per capita alcohol consumption, and death from cirrhosis of the liver. The higher the consumption, the greater the cirrhosis death rate.

In France, where per capita consumption in 1969 was almost 25 litres of absolute alcohol annually (two and a half times higher than Canada), the cirrhosis death rate was almost 52 per 100,000 adults. This was the highest cirrhosis death rate in the world.

In Finland, where per capita consumption was down to just 4 litres of absolute alcohol per capita, the cirrhosis death rate was low at 5.4 per 100,000 people. Also, the relative price of alcohol was higher in Finland than in any other nation in the survey, in France the relative price was lowest.

In Ontario, in 1928, alcohol consumption was 2.8 litres of absolute alcohol per capita (persons 15 or over). The death rate from cirrhosis was 4.4 per 100,000 adults. Four years later, the consumption had quadrupled and so had the liver cirrhosis death rate. During that same period the cost of alcoholic beverages (in terms of buying power) has consistently dropped (See Table 2).

TABLE 2. ALCOHOL CONSUMPTION, RELATIVE PRICE OF BEVERAGE ALCOHOL, AND DEATHS FROM LIVER CIRRHOSIS IN PROVINCE OF ONTARIO, CANADA, 1928-1967*

Year	Alcohol consumption [a]	Relative price [b]	Deaths from cirrhosis of the liver
1928	2.81	0.102	4.4
1929	3.09	0.099	4.1
1930	3.00	0.101	3.8
1931	2.64	0.112	4.0
1932	2.05	0.148	4.2
1933	1.77	0.153	4.2
1934	2.09	0.137	4.2
1935	2.41	0.112	4.2
1936	3.05	0.097	4.2
1937	3.36	0.086	4.5
1938	3.68	0.085	5.0
1939	3.55	0.082	5.2
1940	3.64	0.074	5.0
1941	4.00	0.068	4.9
1942	4.73	0.063	5.0
1943	4.91	0.064	4.8
1944	4.46	0.069	4.6
1945	4.86	0.064	4.9
1946	5.82	0.069	5.4
1947	6.50	0.065	6.0
1948	7.09	0.057	6.5
1949	7.18	0.058	7.2
1950	7.23	0.055	7.7
1951	7.23	0.052	7.5
1952	7.32	0.051	7.7
1953	7.64	0.055	8.3
1954	7.73	0.056	8.7
1955	7.55	0.047	8.8
1956	7.91	0.045	9.4
1957	7.86	0.044	10.3
1958	7.96	0.043	11.0
1959	7.77	0.043	11.5
1960	8.14	0.043	11.8
1961	8.14	0.043	11.6
1962	8.23	0.041	11.3
1963	8.46	0.040	11.4
1964	8.73	0.039	11.9
1965	8.77	0.038	12.6
1966	9.18	0.039	12.9
1967	8.91	0.035	13.2

* Popham, R.E., Schmidt, W. & de Lint, J. (1975) The prevention of alcoholism: epidemiological studies of the effect of government control measures. In: Ewing, J. A., ed., *Drinking*, Chicago, Nelson-Hall (in press).

[a] Litres of absolute alcohol consumer *per capita* for persons aged 15 and older.

[b] Average price of 10 litres of absolute alcohol divided by personal disposable income.

[c] Centred two-year moving averages of deaths from liver cirrhosis per 100 000 persons aged 20 and older, corrected to allow for the differences between the Fifth and Sixth Revisions of the International List of Diseases and Causes of Death (see Popham, R. E. (1956) *Quart. J. Stud. Alcohol*, 17, 570; World Health Organization (1952) *Comparability of statistics on causes of death according to the Fifth and Sixth Revisions of the International List, Geneva).*

Social Customs and the Alcoholic

The alcoholic does not function in isolation from the mainstream of "normal" drinkers.

Mr. X, a moderate drinker, may decide for some reason to increase his alcohol consumption by 25 percent compared to last year. Consequently, the probability of his friends being offered a drink when they visit him is correspondingly increased. The friends consumption level is therefore raised. It is like a stone thrown in a pond: the wave spreads.

Mr. Y, a heavier drinker, sees Mr. X and his friends drinking more and he too will take advantage of the increased opportunities to drink. Only in Mr. Y's case, he crosses over from being a moderately heavy consumer to being a heavy drinker.

In effect, there is a continuum between low and high risk drinking, with no clear demarcation between the two. The populations are inextricably linked.

Jan de Lint, and Wolfgang Schmidt, scientists at the Addiction Research Foundation defined that link and its ramifications this way:

"As long as we looked upon alcoholics and social drinkers as two entirely separate groups, it was reasonable for us to ignore drinking in general and to concentrate on rehabilitation of alcoholics. But now our studies have shown that these groups are not separate populations. We have been forced to realize that there is no great hope of reducing the numbers of alcoholics or those who drink to levels hazardous to their health without rolling back the overall consumption of alcohol throughout our society."— *M.K.*

Toward Saturation: In Search of Control

H. David Archibald

A Guelph, Ontario newspaper reported a rather bizarre incident at a high school in that town. Apparently, teachers had become so upset about their students returning drunk from lunch on their last day of school (as had been occurring in the past few years), that they shuffled the afternoon classes so as not to force the youngsters to return after their visit to a tavern.

It was a routine news report, received a modest two-column headline, and went on to oblivion. To some readers, I suppose it was mildly interesting, to others, a bit of a joke. And that was that. Except that the incident was not really as rare as we might believe.

As the final report of the LeDain Commission states:
"...There must be very few people who do not use some psychotropic drug for non-medical reasons. The general climate, therefore, is not one of moral condemnation of the use of drugs for mood-modifying purposes, but rather one of acceptance of such use."

The report goes on to say:
"It is unrealistic to expect the majority of people to give up non-medical drug use altogether. But it is feasible to attempt to persuade people to reduce their overall use in order to reduce harmful use, and to set a better climate of example for young people."

It is this apparent dichotomy between use and abuse that causes so much anguish when we try to define practical policies concerning alcohol use.

It is part of a trend which reflects youth's growing fascination with the most popular of all psychoactive drugs, a trend which was sharply accelerated by the lowering of the legal drinking age. Young people are drinking more, and they are drinking more often. But equally distressing is the fact that they are doing so with the full blessing of a society that perceives alcohol as a necessity.

A Growing Cynicism

Abuse of alcohol is the greatest drug problem our society faces. Yet

alcohol is a drug which we obviously value, and in which most individuals believe they find more benefit than they do harm.

I concur with the LeDain report that there is no way we would consider returning to policies of total abstinence as we tried in the 1920s. But I wonder if we have not been unwise in letting that experience—as ill-conceived as some may believe it was—propel us so far in the other direction? One of the legacies of that very unpopular action was not only an abhorrence of prohibition, but a growing cynicism about government's role in regulating or restricting the availability of alcohol.

To the Left of Government

I believe we have over-reacted and gone too far in rejecting the use of government policies designed to limit the availability of potentially dangerous drugs such as alcohol. I believe there is immense risk in letting marketplace supply and demand be the sole factors determining availability and distribution of alcohol.

In the making of the drug abuser—whatever that drug is—there are three interrelated components: the substance; the person who uses that substance; and the environment in which the person uses it. Any policy that fails to concentrate on all of these components will achieve little.

When this society turned its back on control mechanisms, and embraced policies of greater and greater liberalization, it did so at an enormous price—in terms of dollars as well as human suffering. And if we continue, unremittingly, toward policies of saturation, that price is bound to inflate.

What Price Freedom?

The Alcoholism Foundation of British Columbia has estimated that alcohol misuse costs Canadian industry $1 million per working day—that is $250 million annually. At the Addiction Research Foundation we estimated, as far back as 1971, that Ontario was spending at least $134 million per year for alcohol-related illness and disruption, through hospital costs, the mental health system, the Family Benefits Act, and the children's aid societies. If this figure were projected across Canada, it would amount to $375 million, and that would not even include the costs of physicians' fees and municipal welfare payments.

A report submitted last August to the Ontario provincial secretary for justice, by the Interministerial Committee on Drinking and Driving, estimated that the annual dollar costs of alcohol-involved collisions ran to $130 million in this province alone.

If we projected this across Canada, we would see the costs of collisions soar to $350 million annually. Just these costs alone—industrial, health, and traffic—add up to one billion dollars annually for Canada, and there are many others such as those related to the criminal justice system, fires, and accidents other than those involving motor vehicles that remain to be tallied.

Last summer, the Second Special Report to the United States Congress on Alcohol and Health estimated that alcohol-related problems cost that country over $25 billion in terms of the value of output or production that must be foregone by society because of alcohol misuse and alcoholism. If the Canadian estimate can be indexed at 10 percent of the American, then the total dollar costs of alcohol-related problems here could be as high as $2.5 billion.

The Effect on Health

In 1973, more than 2,500 Canadians died of liver cirrhosis. In Ontario in 1972, there were 921 deaths from the disease and A.R.F. scientists estimate that 60 percent of liver cirrhosis deaths in the province are attributable to heavy alcohol consumption. In countries where the rate of alcoholism is even higher, the number of deaths from the disease is that much greater. In France and Chile, for example, both of which have high alcohol consumption, almost 90 percent of liver cirrhosis deaths are attributable to this drug.

Between 1965 and 1972, cirrhosis deaths in Ontario increased by 79 percent and cirrhosis is expected to be the fourth leading cause of death (among males between the ages of 35 and 50) in the next 10 years. As cirrhosis has always been intricately related to alcoholism, it has been perceived as the alcoholic's disease. But now we see many diverse forms in which alcoholic illness manifests itself.

Heavy use of alcohol has been implicated in the development of certain cancers, especially of the upper digestive and respiratory systems. In studies done by the A.R.F., we found that 16 percent of

deaths due to the combined group of cancers of the mouth, larynx, pharynx, and esophagus occurred among alcoholics or persons with a history of heavy alcohol use. In a follow-up of more than 6,000 individuals treated between 1951 and 1963, we found cancer of the mouth, pharynx, and larynx five times more frequent among alcoholics than the general population.

We have also found that deaths from pneumonia are three times more prevalent among alcoholic men than among the general population, and seven times more prevalent among alcoholic women.

There is mounting evidence of a causal link between alcohol use and cardiomyopathy, hypertension, and certain other cardiovascular diseases.

There is also a link between alcohol use and peptic ulcers and gastritis, both acute and chronic, and studies in Japan and Norway are giving strong indication of a link between heavy alcohol use and premature death from pancreatic cancer.

As for sudden death from accident, we have heard many times that alcohol is involved in over 50 percent of deaths due to traffic mishaps in Canada. But what is not as widely publicized is the deep involvement of alcohol in non-motor vehicle accidents. For example: Statistics Canada reports the use of alcohol has been implicated in 42 percent of drownings caused by boating misadventures and 28 percent of drowning by swimming. This is a staggering figure considering that between 1968 and 1972 there were 6,500 drownings in Canada.

In 1972, alcoholic psychosis and alcoholism accounted for over 17 percent (over 9,000) of the first admissions, and 16 percent of readmissions, to psychiatric wards and institutions in the country. Of these admissions 92 percent were diagnosed as "alcoholism" (which includes episodic excessive drinking, habitual excessive drinking, and alcohol addiction). The others are classified as "alcoholic psychosis," which would include delirium tremens, paranoia, and hallucinations.

A Neglected Priority

There is one phenomenon that only now is starting to come clearly into focus as a major priority, one which has been tragically neglected

throughout the social development of this country—the health status of our native people. We don't yet have precise statistics but we do know that the use of alcohol is causing enormous problems within these groups in the more remote areas of the country.

Heavy drinking is described by the Union of British Columbia Indian Chiefs as "epidemic" in proportion. It has been estimated that the life expectancy of native heavy drinkers is 30 to 40 years less than the national average, that the accidental death rate is four times greater, and the suicide rate three times greater than the rate among non-native populations. Any way we interpret these data and these observations, we must come to one common conclusion: that from this society's growing dependence on alcohol use has emerged a public health problem of the highest priority.

In terms of costs to the health care system, in terms of personal agony and suffering, there is no question that the public health of this society is endangered by abuse of alcohol. The first reaction of many people to such a comment and the preceding statistics is often guarded. After all, it is largely the heavy drinker and the alcoholic—a minority—who has to worry. Sure, we should do whatever possible to minimize the impact of alcohol on this group. But once we provide the appropriate treatment facilities, what has alcoholism got to do with the rest of us, with the way we live our lives?

A Concern for All

There are many who would have you believe that the alcoholic is an individual apart, that the problem drinker is a social aberration whose drinking style is unaffected and uninfluenced by the actions of those around him. They say that the "vulnerable" drinker would become and remain an alcoholic regardless of the sanctions society imposed on the use of his favorite beverage.

It's an argument that may be convenient, that may provide the escape hatch we need to dissociate ourselves from any responsibility in the making of an alcoholic. But the argument is a fallacy—and it has been proven a fallacy time and time again.

How often do we hear phrases such as: "Alcohol is not the cause of alcoholism," or "Alcoholism is not found in the bottle, it is found in

the man?" Proponents of such clichés argue, often very effectively, that if alcohol was the chief culprit in the genesis of alcoholism, it would not make sense for 90 percent of the people who do drink not to suffer any ill effects. They say there is some "thing" within certain people that makes them vulnerable to this chemical, that it simply "doesn't agree with them."

One can argue that line, pro or con, for a long time, but I don't really think it matters how it is finally concluded because the argument is irrelevant. I have yet to hear a definition of alcoholism that does not involve, in some way, a confluence of man and beverage, and that really is the point. Whether alcohol is the precipitant component in an individual's alcoholism or not, without the drug there could not be an "alcoholic." The truth is that each one of us, by attitude and by behavior, contribute to the milieu in which the heavy drinker lives and functions. This is not a new concept: John Donne, when talking about "no man being an island," simply added grace and strength to an old idea.

Immense Environmental Pressure

We have seen time and time again that a nation with a low per capita consumption of alcohol has a low prevalence of heavy users, while a nation where alcohol is used widely and in which per capita consumption is high has a proportionately higher rate of alcohol-related disease and death.

The fact remains, that there is a continuum between low risk and high risk drinking, with no clear demarcation between the two. The alcoholic is not an individual apart. He is very much "a piece of the continent, a part of the main." It is not difficult to push a low risk drinker into a high risk pattern given the immense environmental pressures available to us.

When government lowered the legal drinking age from 21 to 18 in Ontario, it was felt by many that the major consequence of that act would be to bring out in the open a subgroup of people who were drinking anyway. After all, how difficult was it for an 18 or 19-year-old to go into a liquor store and pass himself off as a 21-year-old?

But what has occurred, according to evidence we have, as a result of the

lowering of the drinking age and as a consequence of more liberal attitudes to alcohol, has been more than "legitimizing the inevitable." It appears that these actions have themselves fed into and stimulated greater public acceptance of alcohol in situations where it was previously not a factor.

Drinking Age Dilemma

Since the lowering of the drinking age, we have been able to document a significant increase in on-premise drinking by young people, substantial evidence of increased absenteeism and alcohol-related problems in school, and we have seen significantly more young drivers being involved and killed in traffic accidents. The carnage can be directly related to their drinking, not to heightened police sensitivity or across-the-board increases in the numbers driving.

In the city of London, Ontario, in the year immediately following the age law changes, alcohol-related collisions among the 18 to 20-year-olds increased 174 percent. Among 24-year-olds, whose records were used as controls, alcohol-related collisions increased 33 percent. The total increase in incidence of collision cases in which the driver had been drinking was most prominent among the 18-year-olds (300 percent) and among the 19-year-olds (348 percent).

In terms of alcohol-related health problems, the Foundation's treatment personnel report a five-fold increase of young people (under 21) coming in for treatment services, and a four-fold increase in under 21-year-olds referred for detoxication.

Now certainly, lowering the drinking age was not the only stimulus to these dramatic increases. In recent years, even before that change, we had seen drinking patterns developing at younger and younger ages. But we cannot neglect the fact that lowering of the drinking age was a deliberate, legislated act, one that was felt to be socially acceptable at the time, and one whose consequences are readily subject to scientific scrutiny.

A Worldwide Trend

Too often, we look at these various trends and we see them as separate issues: young people drinking more, and drinking more often; heavy drinkers turning up with greater varieties of pathology; native

populations decimated by their abuse of alcohol; drinking drivers killing themselves and others with greater frequency.

But they are not really separate issues, they are not confined to Ontario, or Canada. The trend to alcohol saturation is a worldwide phenomenon and as such it becomes even more difficult for us to control our own destiny—even if we had the will to do so.

The production of pure alcohol, as it is contained in the various beverage forms, jumped from 65 million litres (14.3 million gallons) in 1960 to 85 million litres (18.7 million gallons) in 1968—that is throughout the world.

In 33 countries listed in one survey covering 1950 to 1970, average per capita consumption rose in all but four of them (France, Cuba, Cyprus, and Israel showing the only reduction).

On another scale of 49 countries, calibrated for the year 1971, per capita alcohol consumption in Canada ranked 16th from the highest, considerably below France and Italy but above the United States, the U.K., Sweden, Japan, the USSR, and many others.

According to new figures released by Statistics Canada, sales of all alcoholic beverages increased 11.2 percent in fiscal 1973-74 compared to fiscal 1972-73. Spirit consumptions increased the most, jumping by 11.7 percent, compared to a 7.5 percent increase for wine and a 5.3 percent increase for beer. In dollar terms, Canadians spent $263 million more on alcohol than in 1972-73.

During 1973-74, the people of Ontario spent $478 million on spirits, $105 million on wine and $382 million on beer, making them the biggest consumers in the country.

Inevitable Consequences

Since 80 percent of Ontario adults already drink some alcohol, and since 10 to 15 percent of these individuals drink to the point of risking health damage, if we allow an increase in overall consumption we must clearly face two inevitable consequences: people who do not now drink, must start drinking; people who now drink, must drink more. In either case, greater numbers of people become vulnerable to destructive drinking styles.

Unless we are prepared to tolerate a broad assault on our health status through this kind of accelerated drinking, I believe we have no option but to dig in our heels. And I am not just talking about discouraging drinking among subgroups—such as those who are already problem drinkers, or young people, or native peoples—but among all the diverse groups which make up our society, and which influence the overall attitudes and sanctions of the mainstream.

If by our customs we characterize non-drinkers as oddities, if by rejecting an alcoholic drink we are considered antisocial, if robust drinking is equated with strength and manliness, if we refuse a voice to those groups who would seek to counterbalance the immense strength of the merchandisers of alcohol, if we fail to provide socially-acceptable alternatives to drinking, then how can we expect individuals, standing alone, to exercise their "better judgment?"

Education Important but...

It would take extraordinary personal strength to counter all of these social forces, despite all the education programs we may devise. As the LeDain report noted: "Wisdom does not automatically flow from the provision of ample and accurate information, important as such information is...."

Let me emphasize, "important as such information is." In recent months, the Ministry of Health of Ontario, supported by the resources of the A.R.F., mounted a public education campaign to provide information about the possible consequences of alcohol abuse, and to get people thinking about the options they might exercise when faced by this society's mounting pressures to consume more and more alcohol. That was a critical initiative and is an essential first step towards modifying those attitudes that have given alcohol such a social prominence today. But it cannot end there.

One of the most common misconceptions about public attitudes is that our contemporary society demands unceasing liberalization of the regulations that control alcohol use. Social policy makers are constantly being exhorted by our media to adopt more "civilized" laws with respect to where and under what conditions people be allowed to drink. But, in fact, when we analyze these attitudes—as we did in a recent


CINZANO

series of studies* conducted by the A.R.F.—we find a somewhat different interpretation.

The research shows that a majority of respondents favor a restriction on sales to alcoholics, that they reject increasing the number of taverns and licensed restaurants, that most want no increase in the number of liquor outlets or in their hours of sale, and that a majority reject expanding the number of self-service liquor stores.

Even more encouraging was the fact that the respondents accepted the validity of such controls on the basis of public health grounds. The survey was even able to conclude that if the control of beverage prices could be seen by the public as a health-related measure, many of those who want government to maintain current prices or reduce them might be persuaded to change their views. I believe such findings, if they are a true reflection of what our society thinks, are exceedingly important as we contemplate the various control measures available to us.

What Are the Options?

The fundamental point of any program that seeks to resolve the problem of addiction—whether it be to heroin, barbiturates, alcohol, or other drugs—is that it concentrates on suppressing supply as well as demand. Pushing ahead with programs of preventive education, and continuing to pump money into treatment and rehabilitative facilities while permitting alcohol not only to be so freely available but to be promoted as a social necessity, is an unbalanced policy. It is just as unbalanced as trying to coerce Turkey to limit the growing of opium, while doing little to curb the conditions under which heroin use flourishes in North American cities. It suggests that by cutting off one source of supply, the resourceful drug trade entrepreneur will pack in his network and find other employment.

Now I don't mean that we should prohibit the use of alcohol as we have prohibited the use of heroin. But let's not be so vehement in rejecting the possibility that certain types of controls, *developed in concert with a public recognition of the need for some controls,* might in fact prove very effective.

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* The Foundation's evaluation studies department polled 1,000 Ontario residents for its Social Policy and Alcohol Use Survey. Results will be published, in book form, in 1976.

There are many types of control options available. We can control the number and types of outlets as well as the days and hours of sale. We can control the age at which alcohol is bought and consumed. We can certainly regulate the means by which alcoholic beverages are advertised and marketed, and we can manipulate the level of taxation which reflects on the overall cost of alcohol in the marketplace.

Could we not, for example, establish a moratorium on any further relaxation of alcohol control measures, until we know more clearly what these measures are likely to entail in terms of public health? If we had applied this public health criterion a couple of years ago, I wonder if our legislative policy makers would have been so enthusiastic about lowering the legal drinking age?

A Premium on Good Health

I believe the public is becoming increasingly sensitive to the value of health—not just the absence of disease, but the *feeling* of *good* health, the desire to live life more fully. What we must do is continue to project good health as a negotiable factor, one for which individuals are willing, even anxious to pay. Regardless of what the ultimate choice is, it is going to cost.

In contemplating the kind of world I want for my children, I see freedom of choice as indispensable. I want to feel that they will be free to use their better judgment, that they will not be coerced by deliberate, overt, or subliminal forces whose *only* interest is *self* interest. And above all, I don't want them to put a bargain-basement price tag on so deluxe a commodity as their own health.

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